

DATE SENT _____

HOUSTON INDEPENDENT SCHOOL DISTRICT**Sociological Data/Parent Information***Dear Parent:**This information may help in determining your child's educational needs. Please include any other information that you feel will help us help your child.*

Child: _____ Birthdate: _____ Grade: _____
 School: _____
 Parent: _____ Address: _____ Zip: _____
 Phone#: home: _____ - _____ work: _____ - _____

FAMILY HISTORY:

1. Child lives with: _____ Relationship: _____
2. Father's Occupation: _____ Mother's Occupation: _____
3. Primary language spoken in the home: _____
4. Number of children in the family: _____ Ages: _____
5. Have there been any important changes in the family during the last three years? (For example: job changes, family move, changed schools, births, deaths, illnesses, separation/divorce, etc.) _____

STUDENT INFORMATION**1. IF YOUR CHILD IS NOT YET ENROLLED IN A SCHOOL PROGRAM, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

- a. Does your child understand and follow your directions? _____
- b. How does your child tell you what he/she wants? _____
- c. Can you understand what your child says? _____
- d. How long will your child pay attention to an activity? _____
- e. Is your child toilet trained? Day? _____ Night? _____
2. What does your child like to do? _____
3. Does anything seem hard for your child to do? ☐ YES ☐ NO If YES, please explain: _____
4. Does your child have problems with school work? ☐ YES ☐ NO If YES, please explain: _____
5. Are you worried about your child's behavior at school or at home? ☐ YES ☐ NO If YES, please explain: _____
6. What does your child do when not in school? (For example, watch TV, read, part-time job, play with other children.) _____
7. What activities does the family do together? (For example, watch TV, go camping, and/or participate in hobbies or sports.) _____
8. Which of the following do you use to discipline your child?

<input type="radio"/> Spanking	<input type="radio"/> Extra chores	<input type="radio"/> Time Out	<input type="radio"/> Take away privileges
<input type="radio"/> Grounding	<input type="radio"/> Early Bedtime	<input type="radio"/> Extra privileges	<input type="radio"/> Rewards for good behavior
<input type="radio"/> Other: _____			

 Do these methods of discipline seem to work? ☐ YES ☐ NO

9. Describe your child's behavior at home/in the neighborhood:

- | | | |
|---|--|--|
| <input type="checkbox"/> generally well-behaved | <input type="checkbox"/> gets along well with family members | <input type="checkbox"/> minds well |
| <input type="checkbox"/> appears happy | <input type="checkbox"/> plays well with neighborhood children | <input type="checkbox"/> has nightmares |
| <input type="checkbox"/> is overactive | <input type="checkbox"/> is hostile/aggressive towards others | <input type="checkbox"/> seems anxious/upset |
| <input type="checkbox"/> wets the bed | <input type="checkbox"/> accepts responsibility for chores | <input type="checkbox"/> is shy |
| <input type="checkbox"/> seems unhappy/withdrawn/depressed | | <input type="checkbox"/> is defiant |
| <input type="checkbox"/> participates in organized group activities (sports, scouts, church groups, etc.) | | |

10. Has his/her behavior changed in the last few years? ☐ YES ☐ NO If YES, please explain:

11. How does your child feel about school? _____

12. What else would you like us to know about your child? _____

EVALUATION/SCHOOL HISTORY

1. List all the schools, preschools, and/or daycare facilities your child has attended: _____

2. Has your child ever repeated a grade? _____ If so, which grade(s)? _____

3. Has your child ever been evaluated? (For example: at a school, agency, hospital, or by an OT/PT, speech therapist or psychologist, etc.) If so, please list the date/place: _____

HEALTH HISTORY

1. Has your child had any serious illnesses, been in any accidents, or been hospitalized in the last three years? ☐ YES ☐ NO
If YES, please describe the illness, accident, or reason for hospitalization and give your child's age at the time. _____

2. What time does your child go to bed at night? Does he/she have trouble sleeping? ☐ YES ☐ NO If YES, please describe: _____

YES NO

☐ ☐ Is your child under care of a doctor for a medical condition? If YES, please explain: _____

Name of doctor: _____

☐ ☐ Does your child appear to have any other physical health conditions, including allergies? If YES, please explain: _____

☐ ☐ Has your child ever taken medicine for a long period of time? If YES please explain: _____

☐ ☐ Is your child now taking any medications? If YES, please identify the medicine and what it is for: _____

☐ ☐ Are there any family health concerns you would like us to be aware of? If YES, please explain: _____

☐ ☐ Is your child receiving services from another agency? If YES, please explain: _____

Signature of Parent

DATE: _____

Signature of Interviewer and Title (if obtained by parent interview)

DATE: _____